

Wisconsin Department of Regulation & Licensing

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BOARD OF NURSING

CERTIFICATION FORM FOR ADVANCED PRACTICE NURSE PRESCRIBERS WHO DO NOT CARRY PERSONAL LIABILITY INSURANCE COVERAGE

(Complete all that apply)

A.

I am an advanced practice prescriber who practices as the employee of a health care provider and I am covered by a group liability policy providing individual coverage in the amounts set forth in sec. 655.23(4), Stats. I certify that I will prescribe only within the limits of the policy's coverage, or shall obtain personal liability coverage for independent prescribing outside the scope of the group liability policy or policies.

NAME _____
PLEASE PRINT Signature Date

B.

I am an advanced practice prescriber who practices as the employee of a health care provider and I am covered by a group liability policy providing shared coverage. I certify that I will prescribe only under supervision of and as delegated by a physician or certified registered nurse anesthetist and consistent with the requirements for delegated acts established by secs. N 6.03(2) and (3), Code, or shall obtain personal liability coverage for independent prescribing outside of my employment setting.

NAME _____
PLEASE PRINT Signature Date

C.

I am an advanced practice prescriber who practices as the employee of this state or a governmental subdivision, as defined under sec. 180.0103, Stats. I certify that I will prescribe only within the established scope of my employment, or shall obtain personal liability coverage for independent prescribing outside of my government employment setting.

NAME _____
PLEASE PRINT Signature Date